STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET				
		155135	B. WIN			01/18/2	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
\//EST\/IF	EW NURSING AND	REHABILITATION CENTER			LINIC DR RD, IN 47421		
				<u> </u>	110, 114 47 42 1		(VE)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
F0000							
	This visit was for a	a Recertification and	F00	00			
	State Licensure S	urvey.					
	This visit was inco	onjuction to the					
	Investigation of Co	omplaint					
	IN00122128.	·					
	Survey Dates:						
	January 07, 08, 09, 10, 11, 14, 15,						
	16, 17, and 18, 20						
	10, 17, and 10, 20	713					
	Facility number: (	000060					
	Provider number:						
	AIM number: 100						
	7 100	200000					
	Survey team:						
	Susan Worsham,	RN-TC					
	Sharon Whiteman						
	Kimberly Perigo,						
	RN(1/7/13,1/8/13,	1/16/13)					
	( , . , ,	,					
	Census bed type:						
	SNF/NF: 73						
	Total: 73						
	10(a). 70						
	Census payor type	e:					
	Medicare: 12						
	Medicaid: 53						
LABORATOR	V DIDECTORIC OR PROV	WIDED CHIDDI IED DEDDECENTATIVE'S SI	CNIATION	<b>!</b>	TITI E		(V6) DATE

TITLE

000060

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  OF CORRECTION IDENTIFICATION NUMBER:  155135	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 01/18/2013
WESTVII	PROVIDER OR SUPPLIER  EW NURSING AND REHABILITATION CENTER	1510 C	ADDRESS, CITY, STATE, ZIP CODE LINIC DR PRD, IN 47421	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	Other: 8			
	Total :73			
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.			
	Quality Review completed on January 29, 2013; by Kimberly Perigo, RN.			
	20, 2010, by Millberry Forigo, FMA.			

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135	A. BUILDING	LE CONSTRUCTION  00		) DATE SURVEY COMPLETED 01/18/2013
NAME OF P	ROVIDER OR SUPPLIER		B. WING STE	REET ADDRESS, CITY, ST		
		REHABILITATION CENTER		10 CLINIC DR DFORD, IN 47421		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PLAN OF CORRECTION	(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREF	CROSS-REFERENC	VE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	COMPLETION DATE
F0225 SS=D	483.13(c)(1)(ii)-(ii INVESTIGATE/R ALLEGATIONS/II The facility must have been found neglecting, or mis court of law; or ha into the State nur abuse, neglect, misappropriation any knowledge it law against an erindicate unfitness or other facility stregistry or licensii.  The facility must violations involvir abuse, including and misappropria are reported imm administrator of the officials in accord through establish the State survey.  The facility must alleged violations investigated, and potential abuse with progress.  The results of all reported to the acceptance of the second (including to the second certification agent the incident, and	i), (c)(2) - (4) EPORT NDIVIDUALS not employ individuals who guilty of abusing, streating residents by a ave had a finding entered se aide registry concerning nistreatment of residents or of their property; and report has of actions by a court of inployee, which would for service as a nurse aide aff to the State nurse aide ing authorities.  ensure that all alleged ing mistreatment, neglect, or injuries of unknown source into of resident property ediately to the ine facility and to other lance with State law individuals are thoroughly must prevent further while the investigations must be diministrator or his sentative and to other ance with State law	TA	CROSS-REFERENC	HED I OTHE APPROPRIATE FICIENCY)	DATE
			F0225	What correcti	ve action(s) will	02/11/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00		00	COMPLETED	
		155135	B. WIN			01/18/2013	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	ę.		1510 C	LINIC DR		
WESTVII	WESTVIEW NURSING AND REHABILITATION CENTER			BEDFO	PRD, IN 47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	·	DATE	
					be accomplished for those residents found to have beer		
	Based on record i	review and interview			affected by the deficient	'	
	the facility failed to	o ensure nursing			practice? · Resident C did no	ot	
	staff thoroughly in	vestigated and			have a negative outcome relat		
		_			to the alleged deficient practice	e	
	reported an allega	_			How other residents having		
	the Administrator	and other officials			the potential to be affected b	· I	
	as indicated by th	eir policy and			the same deficient practice we be identified and what	/III	
	procedures for 1 of	of 3 residents			corrective action(s) will be		
	reviewed for resident care. (Resident				taken? · All residents have th	e	
	#C)	(			potential to be affected by the		
	#0)				alleged deficient practice. · Al		
					allegations of abuse/neglect w	rill	
	Findings Include:				be reported to the Administrator/DNS immediatel	lv.	
					and to the residents	ly	
	During review of t	he facility's			representative within 24 hours	of	
		ences on 01/16/13			report. All allegations of		
	•				abuse/neglect will be investiga	nted	
	at 11:00 a.m., the	_			including interviewing all staff involved, to assure all policies		
	occurrence dated	09/14/12, was			and procedures are followed b		
	noted, "Employee	Communication			the Administrator/DNS. · All	<b>,</b>	
	FormNurse (Nu	urse #1) went in this			abuse/neglect allegations will		
	am to help CNA #	2 pull resident			reported to the ISDH within 24 hours by the Administrator/DN	•	
	(Resident #C) up	in bed. Nurse			All staff will be in-serviced or		
	observed resident				abuse/neglect including what		
					constitutes abuse/neglect, to		
	incontinent pad.	·			whom to report abuse and who	en,	
	#1)was called into	room after lunch to			his/her responsibility upon witnessing abuse/neglect, by		
	see resident sittin	g in same BM and			2/11/13 by the SDC/designee,		
	dirty gown. Nurs	e had an			post test included. Any PRN s		
	unassigned CNA	change Resident #C			will be in-serviced prior to their	r	
	_	d (sic)shift reported			next scheduled shift by the SDC/Designee.		
					Non-compliance with these		
	that multiple peop				procedures will result in furthe	r	
	unchangedHal	ll trays were left in			education including disciplinar		

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STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 BUILDING 01/18/2013 155135 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1510 CLINIC DR WESTVIEW NURSING AND REHABILITATION CENTER BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  $\mathsf{TAG}$ REGULATORY OR LSC IDENTIFYING INFORMATION) DATE action. · Administrator/DNS are rooms/insubordinate attitude to responsible to ensure charge nurse/shift supervisors....." compliance. What measures will be put into place or what Written in different handwriting systemic changes will be made underneath this section was, "On Sat to ensure that the deficient [Saturday] 9-15-12 Nurse (Nurse practice does not recur? All allegations of abuse/neglect will #1)reports that residents in this CNA's be reported to the (CNA#2's)section where (sic)not Administrator/DNS immediately changed and had brown rings under and to the residents representative within 24 hours of them." This form was check marked report. · All allegations of at, "Final Written Warning." abuse/neglect will be investigated including interviewing all staff involved, to assure all policies Interview of the DON [Director of and procedures are followed by the Administrator/DNS. · All Nursing] on 01/17/13 at 8:16 a.m., abuse/neglect allegations will be indicated the DON had written on the reported to the ISDH within 24 bottom section of the Employee hours by the Administrator/DNS. · All staff will be in-serviced on Communication Form what was abuse/neglect including what reported to her by Nurse #1. constitutes abuse/neglect, to whom to report abuse/neglect and when, his/her responsibility Interview of Nurse #1 on 01/17/13 at upon witnessing abuse/neglect, 7:46 a.m., indicated CNA #2 was the by 2/11/13 by the SDC/designee, post test included. Any PRN staff CNA assigned to Resident #C on will be in-serviced prior to their 09/14/12. Nurse #1 indicated she next scheduled shift by the SDC/Designee. · went in with an unassigned CNA Non-compliance with these sometime before lunch (but didn't procedures will result in further remember the CNA's name) to pull education including disciplinary action. · Administrator/DNS are resident #C up in bed and saw that responsible to ensure his gown was soiled and had BM on compliance. How the corrective action(s) will be maintained to his bed pad. Nurse #1 indicated she ensure the deficient practice had asked CNA #2 to change the will not recur, i.e., what quality resident's bed pad and gown and she assurance program will be put

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PRINTED: 02/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	00	COMPLI 01/18/	
		155135	B. WING			01/18/	2013
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WESTVIEW NURSING AND REHABILITATION CENTER					RD, IN 47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	, The state of the	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	COMPLETION DATE
	(CNA #2)said she				into place? · The CQI tool for		5.112
	indicated this was	before lunch.			abuse staff interview and abuse prohibition and investigation will		
	Nurse #1 indicated	d that evening shift			be utilized weekly x4, and		
	had called her in a	at shift change to			monthly x6. Findings from the CQI process will be reviewed		
	report there was s	till BM on Resident			monthly and an action plan wil	l be	
	#C's bed pad. Nu	rse #1 indicated			implemented for threshold belo	)W	
	she didn't rememb	per who the evening			95%.Completion Date will be 2/11/2013		
	shift nurse was. N	Nurse #1 indicated					
	that CNA #2 denie	ed leaving the					
	resident on a soiled pad. Nurse #1						
	indicated evening	shift CNA's had					
	reported to her that	at they had found					
	sheets soiled with	brown rings during					
	bed checks at the	start of the evening					
	shift and they had	changed the					
	sheets. Nurse #1	indicated she put a					
	note under the DC	ON's door to inform					
	the DON of the all	legation. Nurse #1					
	indicated she did	not go to look at the					
	soiled sheets, but	she did believe					
	what the CNA's to	old her. Nurse #1					
	indicated the CNA	s's reported they had					
	found brown rings	on Resident #C's					
	sheet						
		The DON was interviewed on					
		01/17/13 at 08:16 a.m. The DON					
		indicated the					
	all	legation occurred on a Friday and					
	she v	was not made aware of it until the					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155135	A. BUILDING		01/18/2013
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			LINIC DR	
WESTVI	EW NURSING AND	REHABILITATION CENTER	BEDFC	PRD, IN 47421	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
		wing Monday. The DON indicated	1112		
		she was made aware of the			
		allegations by an "Employee			
		Communication Form." The DON			
	in	dicated she questioned Nurse #1			
	and	Nurse #1 had reported to her that			
		she didn't see the brown rings but			
	s	second shift had reported it to her.			
	The	DON indicated Nurse #1 had told			
	her (the DON) that the second shift				
		aides had reported dried rings on			
	resi	ident sheets to her (Nurse #1) but			
	t	they (the evening shift CNAs) had			
	cha	nged the soiled sheets. The DON			
	ind	icated she didn't remember if she			
	had	ask who the evening shift CNA's			
	we	ere who made the allegations and			
	the	CNA's were not interviewed. The			
	С	OON indicated she did discuss the			
		allegations with CNA #2 and she			
	b	ecame, "kinda of insubordinate at			
	the ti	ime because she felt like she was			
	t	peing picked on." The "Employee			
	Соі	mmunication Form indicated CNA			
	#2 h	ad refused to sign the form." The			
		DON provided Resident #C's			
	Prog	gress Note dated 09/14/12 at 1:36			
	p.m.,	, which indicated, "Area to coccyx			
	r	esolved at this time. Area healed.			
	Sca	ar tissue remains." This Note was			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155135	B. WINC			01/18/	2013
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
WESTVI	EW NURSING AND	REHABILITATION CENTER			LINIC DR RD, IN 47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
		ned by the ADON. The Director of					
		Nursing further indicated, the					
	á	allegation of neglect had not been					
	reported to the Indiana State						
		Department of Health.					
	A policy titled Abu	use Prohibition,					
	Reporting, and Inv	vestigation (not					
	dated) was provid	led by the DON on					
	01/14/13 at 10:00 a.m. The policy						
	indicated, "It is the	e policy of American					
	Senior Communi	ties to protect					
	residents from ab	use					
	includingnegled	ctNeglect occurs					
	when facility staff	fails to monitor					
	and/or supervise t	the delivery of					
	resident care and	services to assure					
	that care is provid	led as needed by					
	the residents. Ne	eglect occurs when a					
	facility fails to prov	vide necessary care					
	for resident, such	as situations in					
	which residents a	re being left to lie in					
	urine or fecesA	all abuse					
	allegations/abuse	must be reported to					
	the Executive Dire	ector immediately,					
	and to the resider	nt's representative					
	within 24 hours of	f the report. Failure					
	to report will resul	It in disciplinary					
	action, up to and i	including immediate					
	terminationIt is	s the responsibility of					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  155135	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY MPLETED 18/2013
	ROVIDER OR SUPPLIER EW NURSING AND REHABILITATION CENTER	1510 C	ADDRESS, CITY, STATE, ZIP LINIC DR DRD, IN 47421	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	the Administrator/Director of Nursing to report the abuse, or allegations of abuse, within 24 hours to the Indiana State Department of Health"  3.1-28(c) 3.1-28(d)	TAG	DEFICIENCY)	EAPPROPRIALE	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00		00	COMPLETED	
		155135		B. WING 01/18/			2013
			1		ADDRESS, CITY, STATE, ZIP CODE	<b>-</b>	
NAME OF P	ROVIDER OR SUPPLIER			1510 C	LINIC DR		
WESTVIE	EW NURSING AND	REHABILITATION CENTER		BEDFO	PRD, IN 47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG F0226		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
SS=D	ETC POLICIES The facility must of	MENT ABUSE/NEGLECT,  develop and implement  nd procedures that prohibit					
		glect, and abuse of sappropriation of resident					
			F02	26	What corrective action(s) will	1	02/11/2013
	Based on record r	review and interview			be accomplished for those residents found to have been	,	
	the facility failed to	o ensure			affected by the deficient	•	
	implementation of	their policy and			practice?		
	procedures for 1 c	of 3 residents			Decident C did not have		
	reviewed for allege	ed neglect of			<ul> <li>Resident C did not have negative outcome related to th</li> </ul>		
	resident care. (Re	sident #C)			alleged deficient practice		
	Findings Include:				How other residents having to potential to be affected by the same deficient practice will be	e oe	
	During review of the	he facility's			identified and what corrective action(s) will be taken?	е	
	reportable occurre	ences on 01/16/13					
	at 11:00 a.m., the	following			<ul> <li>All residents have the potential to be affected by the</li> </ul>		
	occurrence dated	09/14/12, was			alleged deficient practice.		
	noted, "Employee	Communication			All allegations of	to	
	FormNurse (Nu	rse #1) went in this			abuse/neglect will be reported the Administrator/DNS	ເປ	
	am to help CNA #	2 pull resident			immediately and to the resider		
	(Resident #C) up i	in bed. Nurse			representative within 24 hours report.	UI	
	observed resident				· All allegations of		
	incontinent pad. N	,			abuse/neglect will be investiga including interviewing all staff	ited	
	#1)was called into	room after lunch to			involved, to assure all policies		
	see resident sitting	g in same BM and			and procedures are followed b	У	
	dirty gown. Nurse	e had an			the Administrator/DNS.  All abuse/neglect		
	unassigned CNA	change Resident #C			allegations will be reported to	the	
			ı		1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155135	B. WING			01/18/2013	
NAME OF F	DROWNER OR GURRI IEI		-		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF			1510 CI	LINIC DR		
WESTVII	EW NURSING AND	REHABILITATION CENTER		BEDFO	RD, IN 47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)		TAG	ISDH within 24 hours by the	DATE	
	at that time 2nd (sic)shift reported				Administrator/DNS.		
	that multiple peop	ble were left			· All staff will be in-service		
	unchangedHal	Il trays were left in			on abuse/neglect including wh constitutes abuse/neglect, to	nat	
	rooms/insubordina	ate attitude to			whom to report abuse and who	en,	
	charge nurse/shif	t supervisors"			his/her responsibility upon		
	Written in differen	t handwriting			witnessing abuse/neglect, by 2/11/13 by the SDC/designee,		
	underneath this s	ection was, "On Sat			post test included. Any PRN s	staff	
	[Saturday] 9-15-1	2 Nurse (Nurse			will be in-serviced prior to their next scheduled shift by the	r	
	#1)reports that re	sidents in this CNA's			SDC/Designee.		
	(CNA#2's)section	where (sic)not			Non-compliance with th		
	changed and had	brown rings under			procedures will result in furthe education including disciplinar		
	them." This form	was check marked			action.	,	
	at, "Final Written	Warning."			· Administrator/DNS are		
					responsible to ensure compliance.		
	Interview of the D	ON [Director of					
	Nursing] on 01/17	7/13 at 8:16 a.m.,			What measures will be put in	nto	
	indicated the DON	N had written on the			place or what systemic changes will be made to		
	bottom section of	the Employee			ensure that the deficient		
	Communication F	orm what was			practice does not recur?		
	reported to her by	Nurse #1.			· All allegations of		
					abuse/neglect will be reported	to	
	Interview of Nurse	e #1 on 01/17/13 at			the Administrator/DNS immediately and to the resider	nts	
	7:46 a.m., indicate	ed CNA #2 was the			representative within 24 hours		
	CNA assigned to	Resident #C on			report. All allegations of		
	09/14/12 . Nurse	e #1 indicated she			abuse/neglect will be investiga	ated	
	went in with an ur	nassigned CNA			including interviewing all staff		
	sometime before	lunch (but didn't			involved, to assure all policies and procedures are followed by		
	remember the CN	IA's name) to pull			the Administrator/DNS.		
	resident #C up in	bed and saw that			· All abuse/neglect allegations will be reported to	the	
	his gown was soil	led and had BM on			ISDH within 24 hours by the		

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00		00	COMPLETED	
		155135	B. WIN			01/18/2013	
NAME OF I	PROVIDER OR SUPPLIER	3	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					LINIC DR		
WESTVI	EW NURSING AND	REHABILITATION CENTER		BEDFO	RD, IN 47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  CLSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETIC DATE	ϽN
TAG		· · · · · · · · · · · · · · · · · · ·	1	IAG	Administrator/DNS.	DATE	
	_	se #1 indicated she			All staff will be in-service	ed	
	had asked CNA #	_			on abuse/neglect including wh	at	
	resident's bed pa	d and gown and she			constitutes abuse/neglect, to whom to report abuse/neglect		
	(CNA #2)said she would. Nurse #1				and when, his/her responsibilit	y	
	indicated this was	s before lunch.			upon witnessing abuse/negled		
		ed that evening shift			by 2/11/13 by the SDC/design post test included. Any PRN s		
	had called her in	at shift change to			will be in-serviced prior to their		
	report there was	still BM on Resident			next scheduled shift by the SDC/Designee.		
	#C's bed pad. Νι	urse #1 indicated			Non-compliance with the	ese	
	she didn't remem	ber who the evening			procedures will result in furthe	r	
	shift nurse was. I	Nurse #1 indicated			education including disciplinar action.	У	
	that CNA #2 deni	ed leaving the			· Administrator/DNS are		
	resident on a soile	ed pad. Nurse #1			responsible to ensure		
	indicated evening	shift CNA's had			compliance.		
	reported to her th	at they had found			How the corrective action(s)		
	sheets soiled with	n brown rings during			will be maintained to ensure		
	bed checks at the	e start of the evening			the deficient practice will not recur, i.e., what quality		
	shift and they had	I changed the			assurance program will be p	ut	
	sheets. Nurse #1	indicated she put a			into place?		
	note under the D0	ON's door to inform			· The CQI tool for abuse staff		
	the DON of the al	legation. Nurse #1			interview and abuse prohibition and		
	indicated she did	not go to look at the			investigation will be utilized weekly		
	soiled sheets, but	she did believe			x4, and monthly x6  Findings from the CQI proce.	ss	
	what the CNA's to	old her. Nurse #1			will be reviewed monthly and an		
	indicated the CNA	A's reported they had			action plan will be implemented for		
		s on Resident #C's			threshold below 95%.		
	sheet						
		The DON was interviewed on					
		01/17/13 at 08:16 a.m. The DON					

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Event ID: 8S9M11

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED			
ANDILAN	or correction	155135	A. BUILDING		01/18/2013	
			B. WINGSTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			CLINIC DR		
WESTVI	EW NURSING AND	REHABILITATION CENTER	BEDFO	DRD, IN 47421		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE COMPLETION DATE	
	TEGOETTORT OR	indicated the			5.112	
	allegation occurred on a Friday and					
		was not made aware of it until the				
	follo	wing Monday. The DON indicated				
		she was made aware of the				
		allegations by an "Employee				
		Communication Form." The DON				
	in	dicated she questioned Nurse #1				
	and Nurse #1 had reported to her that					
	she didn't see the brown rings but					
	second shift had reported it to her.					
	The	DON indicated Nurse #1 had told				
	he	er (the DON) that the second shift				
		aides had reported dried rings on				
	resi	dent sheets to her (Nurse #1) but				
	t	they (the evening shift CNAs) had				
	cha	nged the soiled sheets. The DON				
	ind	icated she didn't remember if she				
	had	I ask who the evening shift CNA's				
	we	ere who made the allegations and				
	the	CNA's were not interviewed. The				
	D	OON indicated she did discuss the				
		allegations with CNA #2 and she				
	b	ecame, "kinda of insubordinate at				
	the ti	me because she felt like she was				
	k	peing picked on." The "Employee				
	Cor	mmunication Form indicated CNA				
	#2 h	ad refused to sign the form." The				
		DON provided Resident #C's				
	Prog	ress Note dated 09/14/12 at 1:36				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155135	A. BUILDING 00		COMPLETED 01/18/2013
		100100	B. WING	ADDRESS STATE THE CODE	01/10/2013
NAME OF P	PROVIDER OR SUPPLIER	t .		ADDRESS, CITY, STATE, ZIP CODE LINIC DR	
WESTVIEW NURSING AND REHABILITATION CENTER			BEDFORD, IN 47421		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE COMPLETION DATE
	p.m., which indicated, "Area to coccyx				
	resolved at this time. Area healed.				
	Scar tissue remains." This Note was				
	signed by the ADON. The Director of				
	Nursing further indicated, the				
	allegation of neglect had not been reported to the Indiana State				
		Department of Health.			
	A policy titled Abuse Prohibition,				
	Reporting, and Investigation (not				
	dated) was provid	led by the DON on			
	01/14/13 at 10:00 a.m. The policy				
	indicated, "It is the policy of American				
	Senior Communities to protect				
	residents from abuse includingneglectNeglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by				
	the residents. Neglect occurs when a				
	facility fails to prov	vide necessary care			
	for resident, such	as situations in			
	which residents a	re being left to lie in			
	urine or fecesAll abuse				
	allegations/abuse must be reported to				
	the Executive Director immediately, and to the resident's representative				
	within 24 hours of	the report. Failure			

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1510 CLINIC DR				
WEST VIEW NOTCOME TELEVISION OF VIEW				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPL	(X5) IPLETION DATE			
to report will result in disciplinary action, up to and including immediate terminationIt is the responsibility of the Administrator/Director of Nursing to report the abuse, or allegations of abuse, within 24 hours to the Indiana State Department of Health"  3.1-28(a)				

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